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IN THE

Supreme Court of the United States

THE BLACK & DECKER DISABILITY PLAN,
Petitioner,

v.

KENNETH L. NORD,
Respondent.

On Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

BRIEF OF THE AMERICAN MEDICAL ASSOCIATION AS *AMICUS CURIAE* IN SUPPORT OF RESPONDENT

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INTEREST OF *AMICUS CURIAE*

The American Medical Association ("AMA") submits this brief *amicus curiae* in support of respondent.[1] The AMA, an Illinois not-for-profit corporation founded in 1847, is the largest medical society in the United States. Its approximately 260,000 physicians practice in all fields of medical specialization in every state. The AMA is dedicated to promoting the science and art of medicine and the betterment of public health.

The AMA has a unique perspective on the standard of review that should apply under the Employee Retirement Income Security Act, 29 U.S.C. § 1001 *et seq.* ("ERISA"), to eligibility decisions by employee health and welfare plan administrators who operate under conflicts of interest. Every day, physicians throughout this nation are called upon to make judgments regarding whether impairments render their patients disabled under the terms of private health and welfare plans governed by ERISA. These medical judgments by treating physicians are frequently subject to review by plan administrators and by physicians and other health care professionals engaged by those plans. The degree of deference accorded to the medical judgments of treating physicians in these reviews is a matter of substantial importance to these treating physicians – and, more significantly, to the patients for whom they care. For these

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[1] Counsel for the AMA authored this brief in its entirety. The AMA files this brief as a member of the American Medical Association/State Medical Society Litigation Center ("Litigation Center"). The Litigation Center was formed in 1995 as a coalition of the AMA and private, voluntary, nonprofit state medical societies to represent the views of organized medicine in the courts. No monetary contributions to the preparation or submission of this brief were received from any other source. Sup. Ct. R. 37.6. The parties have consented to the filing of this brief, and the consent letters have been filed with the Clerk of the Court. *Id.* 37.3.

reasons, the AMA and its members have a direct interest in the question presented by this case, *i.e.*, the extent to which the fiduciary obligations of a plan to its beneficiaries require a plan administrator to respect the medical judgment of the physician who is responsible for the care of the beneficiary.

In its submission to this Court, petitioner argues that treating physicians frequently engage in deception and exaggeration so that patients can obtain benefits to which they are not entitled. This portrayal of the medical profession is grossly inaccurate and unfair and should play no role in the resolution of the important issue this case presents. A presumption that treating physicians accurately assess their patients' conditions and needs in accordance with the patients' best interests is amply justified by both empirical evidence and by the ethical precepts of the medical profession. Indeed, the ethical obligations of a treating physician closely parallel a plan administrator's fiduciary obligation under ERISA to act in the best interests of beneficiaries. 29 U.S.C. § 1104(a).

In light of that close parallel, when reviewing benefit denials by administrators operating under the conflict of interest that arises when employers both fund and administer plans, courts should apply a modified version of the "treating physician rule" developed in the Social Security context. In particular, a treating physician's judgment concerning the nature of an impairment should be honored unless the plan administrator articulates a substantial basis for deviating from that judgment. This modified treating physician rule helps conflicted ERISA fiduciaries check the impermissible influence of their own financial interest to limit disability payments and ensures that ERISA's abuse of discretion standard plays a meaningful role in detecting and preventing misuses of discretionary authority. At the same time, such a treating physician rule should not unduly interfere with the discretion of administrators in administering plans.

STATEMENT OF THE CASE

Respondent Nord was treated by several physicians in connection with the lower back pain that gave rise to his disability claim. Leo Hartman, M.D., an internist who had treated respondent for several years before the onset of Nord's back condition, diagnosed respondent as suffering from "Lumbar Disc. syndrome." Petitioner's Lodging ("L.") 81, 84. Dr. Hartman based that diagnosis both on physical examinations and on MRI results that revealed degenerative changes of the lower lumbar spine and degenerative disc disease.

Dr. Hartman also referred Nord to Ismael Silva, M.D., an orthopaedic surgeon. Dr. Silva examined the patient on a number of occasions, L. 84-94, and prescribed various pain medications. L. 105-08, 111-12 (copies of prescriptions). Dr. Silva also referred Nord to Dr. Ali for nerve conduction studies and an EMG. Dr. Ali diagnosed the patient with "mild bilateral L5 radiculopathy." L. 97-99 (capitalization omitted). Dr. Hartman also referred Nord to Lytton Williams, M.D., another orthopaedic surgeon, who recommended surgery. L. 43

All of Nord's treating physicians agreed that the patient suffered from degenerative disc disease. Nord underwent physical therapy, including pelvic traction, beginning in August 1997. L. 85-86, 118, 152; see also *id.* at 104, 106, 109-10, 113. Dr. Hartman's notes also reflect that Nord took various medications for his back pain during the summer and fall of 1997. L. 56, 58-59. Despite these measures, Dr. Hartman's notes indicate that Nord's back had not improved and that his pain persisted. L. 55-56. Dr. Silva's notes likewise indicate that, although medication "help[ed]" the patient "tolerat[e]" his pain, L. 87, 89, the pain continued months after he began taking medications and after he underwent traction. See L. 94 (medications prescribed August 15, 1997); L. 87 (noting, nearly five months later, that

Nord was still taking medications and that back pain continued); L. 92, 93 (noting increased pain during period of traction therapy).

While undergoing treatment for his back, Nord filed a claim for disability benefits. The plan administrator, through its agent Metropolitan Life Insurance Company ("MetLife"), rejected that claim in February 1998. MetLife stated that, based on its review of the medical documentation respondent had submitted, his condition "would not preclude [him] from performing [his] job at Black and Decker." L. 145. In support of this conclusion, MetLife cited Nord's ability to take care of his lawn and to do some housework, as well as an office note from Dr. Silva indicating that respondent was "able to tolerate [his] pain with medications." L. 144.

Nord continued to seek treatment for his condition, seeing both Dr. Hartman and Dr. Williams in the spring of 1998. Pet. App. 22-23. In March 1998, Nord underwent a lumbar discogram and CT scan that revealed annular thinning of the intervertebral discs and loss of disc space. L. 51. In April 1998, both physicians completed physical capacity evaluations in which they concluded that Nord could sit for only one hour a day and could lift no more than five pounds. Pet. App. 23.

During this same period, Nord also sought review of the denial of his benefits claim. In connection with that appeal, MetLife arranged to have respondent examined by a neurologist, Dr. Mitri. Dr. Mitri agreed that Nord was suffering from degenerative disc disease, as well as chronic myofascial pain syndrome. Dr. Mitri opined, however, that, "[r]eviewing the patient's job description, and on the basis of the general examination and neurological examination, and after reviewing the report of his tests, I think the patient should be able to do sedentary work with some interruption by walking in between." L. 45. Dr. Mitri further opined that "all the work up that was done did not really show any evidence to substantiate disability in doing sedentary work

with some walking interruption in between." *Id.* Dr. Mitri failed to address the lumbar discogram or the CT scan Nord had undergone a few months earlier, and he offered no further explanation for why he disagreed with the views of Nord's treating physicians, who had each concluded that their patient could not sit for more than one hour each day.

MetLife rejected respondent's appeal, and Black & Decker adopted that denial in a letter dated October 27, 1998. Black & Decker explained that, although Dr. Mitri diagnosed respondent as suffering from degenerative disc disease, as well as chronic myofascial pain syndrome, respondent's "general and neurological examination are essentially normal." L. 156. Black & Decker stated that the tests performed "essentially show no evidence of lumbosacral nerve root compression," and that, although an "EMG and NCS showed bilateral L5 radiculopathy, this was stated to be mild and was not confirmed by the LS MRI that did not show root compression." *Id.* Like Dr. Mitri, Black & Decker did not explain why it disagreed with the conclusion of respondent's treating physicians, nor did it mention the lumbar discogram or the CT scan.

SUMMARY OF ARGUMENT

An ERISA plan administrator owes an "unwavering duty" of loyalty to employees and their beneficiaries. *NLRB* v. *Amax Coal Co.*, 453 U.S. 322, 329 (1981); 29 U.S.C. § 1104(a). However, when a single entity functions as both a funding source and an administrator, it is operating under a conflict of interest. This Court has required that courts pay special attention to such conflicts of interest, *Firestone Tire & Rubber Co.* v. *Bruch*, 489 U.S. 101, 115 (1989), and this critical scrutiny tempers the deference that would otherwise be accorded to a plan administrator executing its discretionary powers. The treating physician rule, which in the ERISA context requires that a plan administrator give an adequate reason if it rejects the opinion of a treating physician,

provides an important means of ensuring that the conflicted administrator has acted consistently with its fiduciary duties. Such presumptive deference to the treating physician implements the ERISA rules articulated by the Department of Labor and imposes no significant additional burden on plan administrators.

Contrary to petitioner's assertions, the rule is well-established in the Social Security context and justified by the medical literature, which shows that treating physicians often have the most information on their patients' conditions, based on their ongoing treatment relationship with the patient. In addition, the rule is supported by a treating physician's ethical duties to act in the patient's best interests. Indeed, the treating physician's fiduciary duty to his or her patient parallels the fiduciary duty owed by the plan administrator to the employee or beneficiary; presumptive deference to the treating physician's opinion thus acts as a check on dual loyalties that may impair a conflicted plan administrator's judgment.

In this case, the plan administrator did not explain why it was rejecting the opinions of Nord's treating physicians, who diagnosed Nord with degenerative disc disease and stated that Nord was unable to sit for more than an hour a day or lift more than five pounds. Nord's job description required him to sit for up to six hours a day and to lift up to twenty pounds. Nevertheless, the doctor hired by the plan administrator to review Nord's claim, Dr. Mitri, declared that Nord was not disabled and could perform his job. The plan administrator denied Nord disability benefits and gave no substantial basis for preferring Mitri's assessment over the treating physicians' conclusions that Nord's disease prevented him from meeting certain basic requirements of his job description. The failure to explain why it was rejecting the opinions of Nord's treating physicians constituted an abuse of the conflicted plan administrator's discretion, and the judgment of the Ninth Circuit should be affirmed.

ARGUMENT

In *Firestone Tire & Rubber Co.* v. *Bruch*, 489 U.S. 101, 113 (1989), this Court held that courts should generally apply a deferential abuse of discretion standard when reviewing discretionary decisions by plan administrators and other fiduciaries, but indicated that a more searching inquiry should apply where a fiduciary acts under a conflict of interest. In this case, the plan administrator was operating under a conflict of interest because it both funded the plan and made benefits decisions under the plan. A rule that requires such a conflicted administrator to provide an adequate explanation when rejecting the presumptively valid views of a treating physician helps to focus the careful inquiry that this Court has required, and ensures that such administrators do not abuse their discretion or violate their fiduciary obligations to beneficiaries.

I. TO ENSURE COMPLIANCE BY ERISA PLAN ADMINISTRATORS WITH THEIR STATUTORY FIDUCIARY DUTY TO ACT SOLELY IN THE INTEREST OF BENEFICIARIES AND PARTICIPANTS, COURTS SHOULD CAREFULLY SCRUTINIZE BENEFIT DENIALS BY ADMINISTRATORS WITH CONFLICTS OF INTEREST.

"ERISA was enacted to promote the interests of employees and their beneficiaries" as participants in employee benefit plans and "to protect contractually defined benefits." *Firestone*, 489 U.S. at 113 (internal quotation marks and citations omitted). To help achieve these "broadly protective purposes," Congress "commodiously imposed fiduciary standards on persons whose actions affect the amount of benefits . . . plan participants will receive," *John Hancock Mut. Life Ins. Co.* v. *Harris Trust & Sav. Bank*, 510 U.S. 86, 96 (1993), including any person who has "any discretionary authority or discretionary responsibility in the administration of such plan." 29 U.S.C. § 1002(21)(A). A plan admini-

strator must "discharge his duties with respect to a plan *solely in the interest of the participants and beneficiaries* and – (A) for the exclusive purpose of: (i) providing benefits to participants and their beneficiaries." *Id.* § 1104(a) (emphasis added).

As this Court has repeatedly recognized, this standard is a stringent one. "ERISA essentially codified the strict fiduciary standards that a [management trustee appointed under § 302(c)(5) of the Labor Management Relations Act] must meet." *NLRB* v. *Amax Coal Co.*, 453 U.S. 322, 332 (1981). Those standards require "an unwavering duty of complete loyalty to the beneficiary of the trust, to the exclusion of the interests of all other parties," and this duty of loyalty "must be enforced with uncompromising rigidity." *Id.* at 329-30 (citation and internal quotation marks omitted). See also *Massachusetts Mut. Life Ins. Co.* v. *Russell*, 473 U.S. 134, 152-53 (1985) (Brennan, J., concurring) ("fiduciaries owe strict duties running directly to beneficiaries in the administration and payment of trust benefits"); *Varity Corp.* v. *Howe*, 516 U.S. 489, 539 (1996) (Thomas, J., dissenting) (describing ERISA's fiduciary standards as "strict"); 120 Cong. Rec. 29929 (1974) (remarks of Sen. Williams) (ERISA imposes "strict fiduciary obligations upon those who exercise management or control over assets or *administration* of an employee pension or welfare plan") (emphasis added).

Drawing on established principles of trust law, this Court has ruled that decisions of plan administrators and other fiduciaries who are exercising discretionary authority to determine eligibility for benefits are generally to be reviewed under an abuse of discretion standard. *Firestone*, 489 U.S. at 115. This deferential standard of review is appropriate where administrators are properly presumed to exercise their discretion in the best interests of participants and beneficiaries. This general presumption – and any judicial deference that flows from it – is unwarranted, however, where a plan vests discretionary authority in an administrator who

has an inherent conflict of interest. A plan administrator who is both the funding source and the decision-maker for the plan operates under a financial conflict of interest. A fiduciary who has dual loyalties "'cannot act exclusively for the benefit of a plan's participants and beneficiaries,'" *Amax Coal*, 453 U.S. at 334 (quoting H.R. Conf. Rep. No. 93-1280, 309 (1974)), and "cannot contend that, although he had conflicting interests, he served his masters equally well or that his primary loyalty was not weakened by the pull of his secondary one." *Id.* at 330 (citations and internal quotation marks omitted). Accordingly, this Court has held that, where a plan vests discretion in "an administrator or fiduciary who is operating under a conflict of interest, that conflict must be weighed as a 'facto[r] in determining whether there is an abuse of discretion.'" *Firestone*, 489 U.S. at 115 (alteration in original) (quoting *Restatement (Second) of Trusts* § 187, cmt. d (1959)).

In this case, "the employer's dual role in funding the plan and deciding claims under it created a conflict of interest that triggered a requirement of more searching judicial review under *Firestone*." Brief of United States as *Amicus Curiae* ("U.S. Br.") at 27. The court below so held, and petitioner did not seek review of that ruling in this Court. As explained below, a properly defined "treating physician" rule is necessary to ensure that a conflicted administrator has, in fact, acted out of "an unwavering duty of complete loyalty to the beneficiary." *Amax Coal*, 453 U.S. at 329.

II. THE TREATING PHYSICIAN RULE, AS MODIFIED IN THE ERISA CONTEXT, IS NECESSARY TO ENSURE THAT CONFLICTED PLAN ADMINISTRATORS PROPERLY DISCHARGE THEIR STATUTORY FIDUCIARY DUTIES TO BENEFICIARIES.

In *Firestone*, this Court did not specify how courts should conduct the more searching review that is required when a plan administrator operating under a conflict of interest denies

a benefits claim. In such circumstances, a plan administrator should be required to provide a substantial written explanation for rejecting the views of a treating physician, and courts should treat an administrator's failure to provide such an explanation as an abuse of discretion. Such a rule flows from the language of both § 1104 and § 1133 and ensures that a conflicted administrator has adequately considered the views of treating physicians, who are obligated (like fiduciaries themselves) to act in the patient's best interests. Such a rule thus serves as a critical check on discretionary benefit denials by administrators laboring under improper "dual loyalties," without unduly burdening administrators or otherwise undermining ERISA's goals.

A. A Treating Physician's Views Are Properly Presumed To Reflect The Patient's Best Interests.

Both the ethical obligations of treating physicians and the empirical data support a rebuttable presumption that a treating physician's views reflect the patient's best interests. In fact, the ethical obligations of physicians to their patients closely mirror the strict duties a fiduciary owes beneficiaries under ERISA. Just as an ERISA fiduciary owes "an unwavering duty of complete loyalty to the beneficiary. . . , to the exclusion of the interests of all other parties," *Amax Coal*, 453 U.S. at 329, treating physicians must "plac[e] patient welfare before all other concerns," and may not, under any circumstances, "place their own financial interests above the welfare of their patients." AMA, *Code of Medical Ethics*, Ops. 8.02, 8.03, *available at* http://www.ama-assn.org/ama/pub/category/2503.html (last updated July 31, 2002); see also *id.* Op. 10.015 (treating physicians have "ethical obligations to place patients' welfare above their own self-interest[s]"). Indeed, a central tenet of medical ethics is that a physician "shall, while caring for a patient, regard responsibility to the patient as paramount." AMA, *Principles of Medical Ethics*, Principal VIII, *available at* http://www.ama-assn.org/ama/pub/category/2512.html (last updated Apr. 2, 2002). Thus,

"[w]ithin the patient-physician relationship, a physician is ethically required to use sound medical judgment, holding the best interests of the patient as paramount." AMA, *Code of Medical Ethics*, Op. 10.015.

In addition to these ethical obligations, treating physicians typically have on-going relationships with the patient and are thus very familiar with the patient's physical and psychological condition, the patient's tolerance for pain, and the patient's ability to benefit from alternative approaches to treatment. In particular, the evaluation of pain, for which there are no objective medical tests, draws on a treating physician's relationship with a patient, for measurement of pain depends on a patient's full communication with the doctor. See 1 *Harrison's Principles of Internal Medicine* 1 (15th ed. 2001) ("*Harrison's Principles*"); *Textbook of Primary Care Medicine* 93 (John Noble ed., 3d ed. 2001) (discussing the patient's report of pain as "the most reliable information available"). Medical literature is clear that patient-physician communication is more thorough and candid in an ongoing physician-patient relationship. See, *e.g.*, Susan A. Flocke et al., *The Impact of Insurance Type and Forced Discontinuity on the Delivery of Primary Care*, 45 J. Fam. Prac. 129, 132 (1997). Moreover, a treating physician's relationship with the patient over time permits the physician to evaluate effectively the results of various treatments and medications on the patient's pain and ability to function.

Recognizing the important insights that a treating physician's relationship to a patient can provide, the federal government has itself endorsed a presumption that the views of treating physicians are valid. Since 1991, regulations promulgated by the Commissioner of Social Security have provided that, in evaluating medical opinion evidence regarding disability determinations, the Commissioner will generally give more weight to opinions from treating physicians because "these sources are likely to be the medical professionals most able to provide a detailed, longitudinal

picture of [the claimant's] medical impairment(s) and may bring a unique perspective to the medical evidence that cannot be obtained from the objective medical findings alone or from reports of individual examinations, such as consultative examinations or brief hospitalizations." 20 C.F.R. § 404.1527(d)(2). Although the Commissioner's views are not binding here, the well-reasoned views of an agency implementing a statute that also governs disability determinations "constitute a body of experience and informed judgment to which courts and litigants may properly resort for guidance." *Bragdon* v. *Abbott*, 524 U.S. 624, 642 (1998) (referring to views of agencies not entitled to *Chevron* deference; internal quotation marks and citation omitted).

The presumptive validity of treating physician views is supported not only by the "experience and informed judgment" of an agency administering a comparable disability program, but by empirical evidence as well. Studies show that continuity of care leads to better patient outcomes. See, *e.g.*, Margaret M. Love et al., *Continuity of Care and the Physician-Patient Relationship: The Importance of Continuity for Adult Patients with Asthma*, 49 J. Fam. Prac. 998 (2000). One such study found that:

> [w]hen patients concentrate their care with a single physician, those physicians are more likely to develop an accumulated knowledge about their patients' medical conditions. This knowledge goes beyond simply knowing the patient's diagnoses and medications. It includes a finer understanding of the severity of each medical problem and how multiple problems interact.

Id. at 1003. Other studies provide additional support for the conclusion that there is a correlation between the quality of primary care and continuity of the patient-physician relationship, see Flocke, *supra*, at 132-33, and that physicians' knowledge of patients is a leading correlate of improved health status. See Dana G. Safran et al., *Linking*

Primary Care Performance to Outcomes of Care, 47 J. Fam. Prac. 213 (1998).

In short, in light of this empirical evidence, as well as the close parallels between the obligations of treating physicians and ERISA fiduciaries to patient-beneficiaries, it is reasonable to assume, in the first instance, that a treating physician's opinion reflects the patient's best interests.

B. A Conflicted Administrator's Failure To Provide An Adequate Written Explanation For Rejecting The Presumptively Valid Views Of A Treating Physician Constitutes An Abuse Of Discretion.

Any presumption that the views of a treating physician are valid must be a rebuttable one. Thus, a conflicted plan administrator is not required to accept the treating physician's opinion. Such an administrator could, for example, reject the treating physician's opinion because the opinion is not "accompanied or supported by objective or clinical findings," because the treating physician "lacked [the] relevant expertise," or because additional medical evidence, such as laboratory results, undermines the treating physician's diagnosis.[2] See U.S. Br. at 15. But the conflicted administrator should set forth these or any other reasons for rejecting the presumptively valid views of a treating physician in a written explanation that the beneficiary and a court may review, and a conflicted administrator's failure to provide an adequate explanation for rejecting the treating physician's views should be treated as an abuse of discretion.

Such requirements advance ERISA's purposes in several ways. First and foremost, the requirement of an adequate

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[2] Such reasons will typically be provided by a physician hired by the plan to conduct an independent medical examination and to review the patient's medical records. Any presumption in favor of the validity of the views of treating physicians, therefore, is not intended to disparage the views of independent medical examiners, who can provide the adequate reasons necessary to rebut that presumption.

written explanation serves as a check on any impermissible influence that the administrator's divided loyalties might otherwise exert on a benefit decision. The obligation to provide a substantial written explanation ensures that a conflicted administrator who is statutorily obligated to act in the beneficiary's best interests actually considers the medical opinion rendered by the treating physician. Indeed, such a requirement helps conflicted administrators themselves guard against unconscious bias. The very exercise of explaining a decision to reject a treating physician's opinion forces the plan administrator to confirm that the decision is based on appropriate medical evidence and the relevant decisional factors. An inability to cite substantial reasons in support of a decision to deviate from a finding of the treating physician regarding impairment of the patient should serve as a warning to fiduciaries that their decisions may be based on improper incentives.

Second, the requirement of a written explanation setting forth a substantial reason ensures that ERISA's abuse of discretion standard plays a meaningful role in detecting and preventing misuses of discretionary authority by fiduciaries. ERISA requires that employee benefits plans "provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant." 29 U.S.C. § 1133(1). A requirement that this statutorily mandated explanation set forth a substantial reason for rejecting the treating physicians' views is analogous to requirements under the Administrative Procedure Act ("APA") that federal courts have long used to ensure the adequacy and propriety of decision-making by entities possessing discretion and substantive expertise. In reviewing the adequacy of a conflicted administrator's decision, courts will be able to ensure that the administrator "examine[d] the relevant data and articulate[d] a satisfactory explanation for

[his] action including a 'rational connection between the facts . . . and the choice made.'" *Motor Vehicle Mfrs. Ass'n* v. *State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983) (quoting *Burlington Truck Lines, Inc.* v. *United States*, 371 U.S. 156, 168 (1962)). Where conflicted administrators cannot satisfy this standard, courts can properly ascribe the failure to the impermissible influence of the conflict, and should invalidate the decision as an abuse of discretion. This "narrow" yet "'searching and careful'" form of review, *Bowman Transp., Inc.* v. *Arkansas-Best Freight Sys., Inc.*, 419 U.S. 281, 285 (1974), thus enables courts to detect deviations from ERISA's strict fiduciary standards.[3]

C. The Arguments Of Petitioner And Its *Amici* Provide No Basis For Rejecting The Treating Physician Rule.

1. The Medical Literature Petitioner Cites Does Not Justify Judicial Rejection of the Treating Physician Rule.

Petitioner argues at length that any presumption that a treating physician's views are correct is a "fallacious," "erroneous" and "outdated stereotype" that has "no place in today's medical managed care marketplace." Petitioner's Br. at 27, 28 and 33 (capitalization omitted). As the AMA has already demonstrated, however, petitioner's bald assertion that "[t]here is no empirical evidence that supports" such a presumption is untrue. See *supra* at 12-13. As just noted, the presumption might be rebutted in appropriate circumstances. See *supra* at 13. But petitioner's broad-based and misguided

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[3] Most courts of appeals already require plan administrators to engage in reasoned decision making when denying a claim. *Pinto* v. *Reliance Standard Life Ins. Co.*, 214 F.3d 377, 393 (3d Cir. 2000); *Donaho* v. *FMC Corp.*, 74 F.3d 894, 899 (8th Cir. 1996); *Pagan* v. *NYNEX Pension Plan*, 52 F.3d 438, 442 (2d Cir. 1995); *but see Gallo* v. *Amoco Corp.*, 102 F.3d 918, 922 (7th Cir. 1996) (noting in dicta that "[t]here is no such requirement [to articulate the grounds for a plan administrator's decision] in the law").

attack on the integrity of the entire medical profession provides no basis for refusing to recognize a rebuttable presumption in the first place. Indeed, in making that attack, petitioner not only mischaracterizes the medical literature, but fails to recognize that a treating physician's role as an advocate for her patient furthers ERISA's goals.

Citing several surveys, petitioner contends that physicians will often lie or exaggerate in order to deceive insurers and obtain benefits for their patients. Petitioner's Br. at 29-33. Only one of these surveys, however, examined actual practices, rather than reactions to hypotheticals,[4] and this survey reported that the vast majority of physicians believe it is morally wrong to "game the system" for a patient's benefit (85%) and unnecessary to do so in order to provide high-quality care (71.5%). Matthew K. Wynia et al., *Physician Manipulation of Reimbursement Rules for Patients: Between a Rock and a Hard Place*, 283 J. Am. Med. Ass'n 1858, 1862, tbl.2 (2000). These views "accord[] with the strongly worded official declarations of professional societies, wherein manipulating reimbursement rules is considered an ineffective and socially irresponsible way to advocate for patients' interests." *Id.* at 1863; see also AMA, *Code of Medical Ethics*, Op. 9.132 (encouraging physicians "to play a key role in identifying and preventing fraud" and exposing "those physicians . . . who engage in fraud or deception.").

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[4] *See* Dennis H. Novack et al., *Physicians' Attitudes Toward Using Deception To Resolve Difficult Ethical Problems*, 261 J. Am. Med. Ass'n 2,980, 2,985 (1989) (seeking response to four hypothetical problems, and noting that the study's "response rate and limited scope *preclude generalizations* about the prevalence and nature of physician deception") (emphasis added); Victor G. Freeman et al., *Lying for Patients: Physician Deception of Third-Party Payers*, 159 Archives Internal Med. 2263, 2270 (1999) (employing 6 hypothetical vignettes, and noting that authors were "unsure of the extent to which" the respondents' willingness to sanction deception in the vignettes "translates into the actual use of deception in practice").

Indeed, the majority of physicians surveyed (61%) reported that they never or rarely misrepresented a patient's symptoms, diagnosis, or severity of illness, even to obtain "coverage for care that the physicians perceive to be *necessary*." Wynia, *supra*, at 1863 (emphasis added). This unwillingness to deceive even to obtain necessary care is particularly significant, because a treating physician can be found negligent for failing to provide necessary care even where an insurer refuses to pay for it.[5] Thus, the very data petitioner cites does not support its sweeping claim that most treating physicians will intentionally misrepresent a patient's condition in order to help the patient obtain benefits for medically necessary treatment, let alone disability benefits that are not essential to the discharge of the physician's legal and ethical obligations to furnish needed medical care.

Petitioner also suggests that any presumption that a treating physician's diagnosis is accurate or valid is fatally undermined by the treating physician's role as a patient advocate. Petitioner's Br. at 31-33. But a treating physician's duty "to advocate for [the] patient's welfare," AMA, *Code of Medical Ethics*, Op. 10.015, is merely an outgrowth of "the imperative to care for patients and to

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[5] *See generally* E. Haavi Morreim, *Gaming the System: Dodging the Rules, Ruling the Dodgers*, 151 Archives Internal Med. 443, 444 (1991) (noting that the governing standard of care requires use of appropriate technologies, regardless of who pays for them); Peter D. Jacobson & Scott D. Pomfret, *ERISA Litigation and Physician Autonomy*, 283 J. Am. Med. Ass'n 921, 923 (2000) (noting that ERISA preemption of many state law claims alleging that managed care organization's denial or delay in care caused an adverse medical outcome means that "the patient's only remedy is to sue the physician, regardless of how much influence over the clinical decision the physician actually exercised"); James S. Forrester et al., *Task Force 1: External Influences on the Practice of Cardiology*, 31 J. Am. Coll. Cardiology 926, 929 (1998) ("ERISA, therefore, creates a unique dichotomy in which the physician may assume the liability for a plan's decision with which he or she does not agree, while the plan's nonphysician decision maker is protected from liability.").

alleviate suffering," *id.* It is this same imperative that gives rise to the physician's obligation "to use sound medical judgment, holding the best interests of the patient as paramount." *Id.* Thus, physicians are "advocates" not for their patients' *pecuniary* interests, but for their patients' *physical and psychological* well-being. The diagnoses of treating physicians are entitled to a presumption of validity, therefore, precisely because these physicians are obligated to furnish the medical care that is in their patients' best interests.

Indeed, the fact that treating physicians must act as advocates for the medical care that is best for their patients militates in favor of judicial recognition of a treating physician rule under ERISA. ERISA requires plan administrators to act out of an unwavering loyalty to, and "solely in the interest of," participants and beneficiaries. 29 U.S.C. § 1104(a). Because ERISA's fiduciary duty of loyalty so closely parallels a treating physician's ethical obligations, courts as well as plan administrators should presume that the diagnosis of a treating physician reflects the best interests of the patient, and that a conflicted administrator's failure to offer an adequate explanation for rejecting that diagnosis constitutes an abuse of discretion.

2. Federal Regulations Support, Rather Than Undermine, the Treating Physician Rule.

The United States argues that the presumption of validity accorded the views of treating physicians under the Social Security Act does not justify use of any similar presumption when courts review ERISA benefit decisions, particularly in view of the Department of Labor's ("DOL") failure to adopt such a presumption in recently promulgated regulations. Contrary to the United States' suggestion, however, the origins of the presumption used in the Social Security context in no way undermine the rationale behind that presumption. Nor do the DOL regulations preclude recognition of the treating physician rule.

The United States notes that the treating physician rule used in the Social Security context originated with several circuit courts, not with the agency itself, and was ultimately adopted to bring uniformity to adjudications under a nationwide program. U.S. Br. at 19-21. The regulation itself, however, expressly states that the treating physician rule is predicated on the fact that treating physicians "are likely to be the medical professionals most able to provide a detailed, longitudinal picture of [the claimant's] medical impairment(s) and may bring a unique perspective to the medical evidence that cannot be obtained from the objective medical findings alone or from reports of individual examinations, such as consultative examinations or brief hospitalizations." 20 C.F.R. § 404.1527(d)(2). The Commissioner reiterated this rationale, moreover, in the commentary explaining the rule's adoption.[6] Whatever the historical origins of the rule, therefore, they do not alter the rule's central rationale, which is that treating physicians are likely to have a unique perspective on a patient's condition and medical needs.[7] That

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[6] *See* 56 Fed. Reg. 36,932, 36,935 (Aug. 1, 1991) (recognizing that "medical opinions—especially those from treating sources – can provide evidence of the nature and severity of an individual's impairment[s] that cannot be obtained by any other means") (alteration in original); *id.* ("We give treating source medical opinions special deference because treating sources usually have the most knowledge about their patients' conditions"); *id.* at 36,936 (rules on weighing treating source opinions that are not entitled to controlling weight were still written "in recognition of the special kind of knowledge about the nature and severity of their patient's impairments that only treating sources can have").

[7] The Department of Labor has similarly explained its version of the treating physician rule in the context of black lung benefits: "special weight may be given a treating physician's opinion because that physician has been able to observe the miner over a period of time, and therefore may have a better understanding of the miner's physical condition." 64 Fed. Reg. 54,966, 54,976 (Oct. 8, 1999). *See also* 65 Fed. Reg. 79,920, 79,931 (Dec. 20, 2000) ("The Department [of Labor] emphasized the real purpose of the rule: to recognize that a physician's professional

same rationale, of course, justifies use of a treating physician rule under ERISA.

Contrary to the government's claim, moreover, the DOL's recently promulgated regulations do not preclude recognition of such a rule. These regulations specify that a plan's procedures for reviewing claims must "[p]rovide for a review that takes into account all comments, documents, records, and other information submitted by the claimant." 29 C.F.R. § 2560.503-1(h)(2)(iv) (2001). In addition, plans providing disability benefits must include either an "explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances," or a statement that such an explanation is available upon request. *Id.* § 2560.503-1(j)(5)(ii), (g)(1)(v)(B) (2001); *compare* 29 C.F.R. § 2560.503-1(f)(1) (1998) (specific reasons for initial denial), *and id.* § 2560.503-1(h)(3) (1998) (specific reasons for the denial on review). The treating physician rule is entirely consistent with these requirements. By requiring that the "explanation of the scientific or clinical" basis for a benefit denial expressly address the treating physician's views, the proposed rule ensures that a conflicted administrator does adequately "tak[e] into account all comments, documents, records, and other information submitted by the claimant." *Id.* § 2560.503-1(j)(5)(ii), (h)(2)(iv) (2001). Absent such a rule, it is far too easy for conflicted ERISA administrators to pay lip service to the DOL regulations without honoring their spirit.

Nor will adoption of a rule that requires substantial reasons for departing from the judgment of the treating physician require any additional new procedures. Instead, the rule relies on procedures that DOL itself has prescribed. It simply specifies the content of the "scientific or clinical" explanation that a conflicted administrator must provide when denying a claim. As the government itself recognizes, where a plan

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relationship with the miner may enhance his or her insight into the miner's pulmonary condition.") (citing 64 Fed. Reg. at 54,976).

administrator "both funds the plan and renders decisions on claims for benefits under it," there is a "special justification for expecting the administrator to explain his consideration of the material evidence submitted by the claimant." U.S. Br. at 17. The treating physician rule serves precisely this interest, using the procedures the government has established.

Finally, for these same reasons, the proposed treating physician rule will not restrict the flexibility "for . . . operating claims processing systems consistent with the prudent administration of a plan," U.S. Dep't of Labor, *Benefits Claims Procedure Regulation*, Question B-4, *at* http://www.dol.gov/ebsa/faqs/faq_claims_proc_reg.html (last visited Mar. 21, 2003) or discourage employers from offering plans by "increasing plan administration, medical expenses and legal costs." Petitioner's Br. at 16. DOL regulations already require an explanation of the denial that includes the administrator's scientific or clinical judgment. Accordingly, a requirement that this explanation address the treating physician's opinion and provide an explanation for why the conflicted administrator has rejected that opinion entails virtually no additional burdens or costs, and does not limit claims processing flexibility. Thus, for example, if such an administrator rejects a treating physician's opinion because it is not accompanied or supported by clinical findings, or because laboratory results not considered by the treating physician undermine the diagnosis, it is a simple matter for the administrator to specify these reasons in the required explanation. Indeed, because a failure to do so cannot be justified by considerations of cost or administrative burden, courts can properly conclude that the failure results from the improper influence of the conflict on the administrator's decision.

D. The Conflicted Plan Administrator Failed To Provide An Adequate Explanation For Refusing To Accept The Views Of Respondent's Treating Physicians.

In this case, because the conflicted plan administrator failed to provide an adequate explanation for rejecting the views of respondent's treating physicians, the lower court properly concluded that the administrator had abused its discretion in denying respondent's benefit claim. As noted above, respondent was examined and treated by a number of physicians practicing in a number of specialties. All of them – including Dr. Mitri, the neurologist selected by MetLife (the plan's designated agent) – agreed that respondent was suffering from degenerative disc disease. Respondent's treating physicians, one of whom examined respondent repeatedly following the onset of his back condition, concluded that respondent could not sit for more than one hour each day.

When the administrator initially rejected Nord's claim, it made no mention of the treating physician's diagnosis of degenerative disc disease. The administrator simply stated that a single office note by Dr. Silva indicated that respondent could "tolerate" pain with medications, and that respondent had indicated that he could do some housework and mow his lawn. L. 144-45. In upholding the benefits denial after appeal, Black & Decker on MetLife's recommendation acknowledged that its own examiner agreed with the treating physicians that respondent suffers from degenerative disc disease, as well as chronic myofascial pain syndrome. Black & Decker nevertheless concluded that respondent was not disabled. L. 156.

None of the reasons Black & Decker recited provides a basis for rejecting the treating physicians' conclusion that respondent could not sit for more than an hour each day. Black & Decker failed to even address two of the tests that the treating physicians had used in their diagnosis. Moreover,

Dr. Mitri's statement that there was no root compression was not relevant to Nord's functioning because there are other causes of degenerative disc disease and pain. Indeed, Dr. Mitri himself was aware that respondent's tests showed no nerve root compression, and that respondent's "general and neurological examination [we]re essentially unremarkable and normal," yet he, too, diagnosed respondent as suffering from degenerative disc disease and myofascial pain syndrome. L. 45. See also John Greer, *Accommodating Individuals with Back Impairments*, U.S. Dep't of Labor, *available at* http://www.nam.wvu.edu (last visited Mar. 10, 2003) (noting that "nerve impingement" is only one of several possible causes of back pain); *Harrison's Principles*, *supra*, at 82 (discussing causes of lumbar disc disease).

The administrator's final decision in fact offers no explanation at all for rejecting the treating physicians' conclusions. And while petitioner faults the treating physicians for failing to review respondent's job description, Petitioner's Br. at 6-7, it is undisputed that his job required respondent to sit for five to six hours a day and required him to lift up to twenty pounds. Pet. App. 20; L. 143. In light of the plan administrator's conflict of interest, this complete failure to explain the basis for rejecting the views of the treating physicians constitutes an abuse of discretion.

Nor is there any reason to remand this case for further consideration of the evidence that petitioner now cites in support of the denial. Given the consensus concerning respondent's diagnosis, the central issues bearing on his ability to perform his job are the amount of pain his condition causes and the extent to which that level of pain impairs his ability to sit. Dr. Mitri opined that respondent "should be able to do sedentary work with some interruption by walking in between," L. 45, but nowhere did he state how many hours of sedentary work he thought respondent could perform, let alone explain why he disagreed with the treating physicians'

view that respondent could not sit for more than an hour a day.

Dr. Hartman's judgment that Nord could not do more than an hour of sedentary work each day was based on no fewer than twelve examinations between July 1997 and March 1998. L. 54-59. Dr. Hartman was fully aware of the medications respondent was taking and their effectiveness. His judgment that respondent could not sit for more than an hour a day was a fully informed one based on sophisticated diagnostic tests and repeated examinations and consultations. See Love, *supra*, at 1003 (treating physicians "develop an accumulated knowledge about their patient's medical conditions" that "goes beyond simply knowing the patient's diagnosis and medications" and "includes a finer understanding of the severity of each medical problem"). That judgment simply was not rebutted by Dr. Mitri's unexplained contrary opinion.

The unsurprising fact that "medication help[ed]" respondent, L. 89, does not cast the slightest doubt on Dr. Hartman's assessment of respondent's ability to do sedentary work. Nor is that assessment undermined by Dr. Silva's unexplained notation that respondent feels "worst [without] medication but is tolerated [with] medications." L. 87. Medically speaking, "tolerating" pain is not synonymous with "functioning normally"; a patient can "tolerate" pain with medication, yet still be unable to sit for more than an hour a day. Finally, the fact that respondent was able to do some housework (with the assistance of his parents) and mow a lawn of unspecified size and gradation in no way establishes that he can sit for more than an hour a day. Black & Decker further appears to have abandoned these reasons by failing to identify them in the final denial of the benefits claim.

In short, the plan administrator failed to provide a substantial explanation for why it was rejecting the views of the patient's treating physician. Nor has it offered any such explanation in its submissions to the lower court or to this

Court. Because the plan was operating under a conflict of interest, this failure should be deemed an abuse of discretion.

CONCLUSION

For the foregoing reasons, the AMA urges the Court to affirm the judgment of the Ninth Circuit in this case.

Respectfully submitted,

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